Medicines Bulletin

September 2017

Haloperidol depot – outcomes for SLAM in-patients at 1 year

In June 2014, we recommended that haloperidol be considered the long-acting injection (LAI) of choice in the trust. This guidance was based on results of a study by McEvoy and colleagues(1) in which haloperidol, initiated according to a prescribed loading and maintenance regime, was found to be more or less equal in efficacy and tolerability to paliperidone long-acting (PPLAI) injection.

We have analysed clinical outcomes at 1-year for in-patients who started haloperidol long-acting injection (HDLAI) between July 2014 and July 2015. In total, of the 84 patients who started HDLAI, only 33% remained on it 12 months later (this compares with a reported 65% continuation rate for paliperidone(2)) .

Overall, there was a reduction in mean hospital admissions in the year following discharge from the admission during which HDLAI was started compared with the year before HDLAI initiation. Bed days did not change for the same period. Outcomes were better for patients who continued treatment than for discontinuers.

Patients with a longer duration of illness were more likely to remain on treatment whilst patients who started HDLAI because of non-adherence were more likely to stop treatment. Age, diagnosis, gender, ethnicity, initiation regimen or maintenance dose did not predict continuation with treatment.

The main reasons for treatment discontinuation were adverse effects and patient choice: a quarter of patients stopped because of adverse effects and a fifth declined to continue with treatment. EPSEs were the most commonly reported adverse effects.

In summary, HDLAI was associated with a high discontinuation rate. Bed days in the year following HDLAI appear to fall but patients spent a long time in hospital during the admission in which HDLAI was initiated: bed days in the time between HDLAI initiation and discharge from hospital amounted to the same as they did in the entire year preceding haloperidol initiation. Continuers generally had better outcomes than discontinuers.

HDLAI may be suitable for a select group of patients. Those are likely to be patients with a longer duration of illness and patients initiated on HDLAI for reasons other than poor adherence.

Fluphenazine depot (Modecate®) – to be discontinued in 2018

The manufacturer of fluphenazine injection (Modecate®) will cease production of the drug sometime next year. All patients currently prescribed fluphenazine long-acting injection (LAI) will need to be switched to an alternative medication before this time.

Choice of alternative long-acting injection (LAI)

Of the LAIs currently available haloperidol decanoate is probably the closest in pharmacological action to fluphenazine decanoate. We also know the relationship between the dose and response for HDLAI and its broad dose-equivalence to fluphenazine. So, we recommend that adults currently prescribed fluphenazine LAI be switched to HDLAI at the doses shown below. HDLAI should be given once every 4 weeks and a baseline ECG is recommended before starting treatment.

Current fluphenazine dose (or equivalent)	Switch to HDLAI
25mg/2 weeks	50mg/4 weeks
50 mg/2 weeks	100 mg/4 weeks
75 mg/2 weeks	150 mg/4 weeks
100 mg/2 weeks	200 mg/4 weeks

Other typical depots may be used where necessary (e.g. in the elderly, for whom haloperidol is rarely prescribed). Approximate equivalent doses are given below.

Fluphenazine 50mg/2 week = Zuclopentixol 400mg/2 weeks
= Flupentixol 80mg/2 weeks

Patients must not be switched from fluphenazine decanoate to aripiprazole, paliperidone or olanzapine LAIs.

Patients do not need a test dose when switching from fluphenazine to another LAI – just substitute the new injection for the fluphenazine when the next dose is due. The dose equivalences shown above are approximate and intended to be used as a guide. Patients should be monitored closely for any changes which may result from the change of drug.

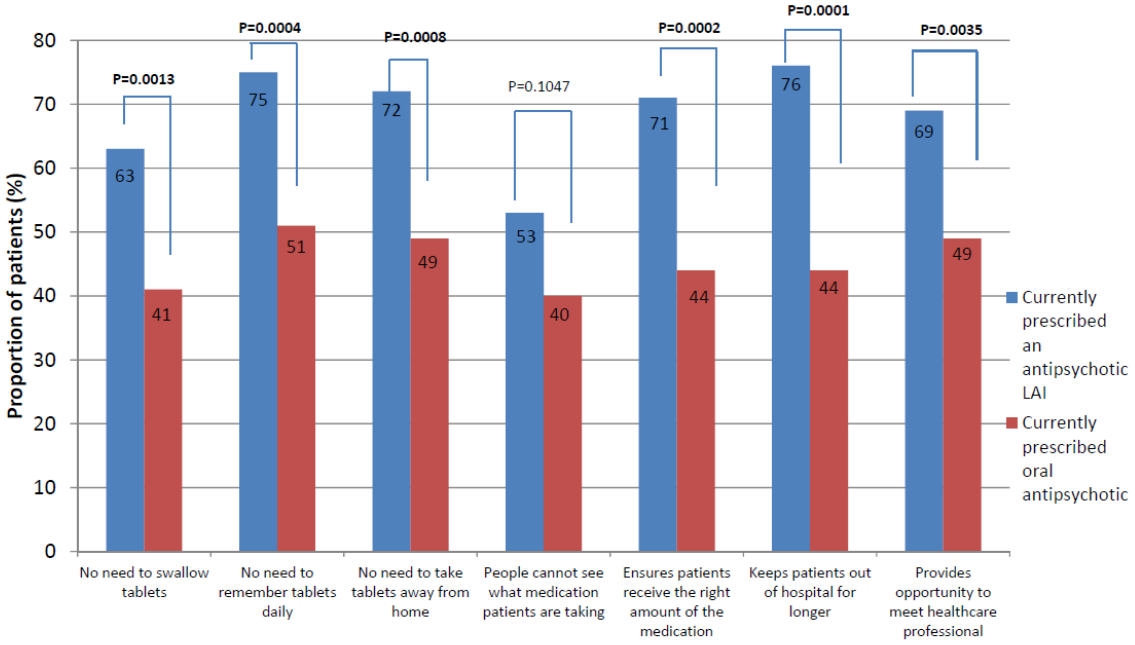
For further information contact Medicines Information on 020 3228 2317

Antipsychotic long-acting injections (LAIs) – patient attitudes survey

We recently surveyed over 200 patients in SLAM community teams about their views on antipsychotic long-acting injections. The group included patients both on LAIs and on oral medication. The results were somewhat surprising, given the informal view within the trust that patients prefer oral medication and that many are reluctant to consider an LAI.

In our survey, the majority of patients agreed with the known benefits of LAIs, such as convenience, and fewer patients were concerned than not about aspects of the injection administration procedure, such as pain from the injection. The majority of patients expressed a preference for the site of injection administration (gluteal or deltoid) and the geographical location of the clinic where the injection is administered. Women were more likely to express a preference for the gender of the person administering the injection and more women than men preferred

administration by someone of the same gender. The graph below shows the proportions of patients prescribed an LAI and oral medication who agreed with the benefits of LAIs stated in the survey.

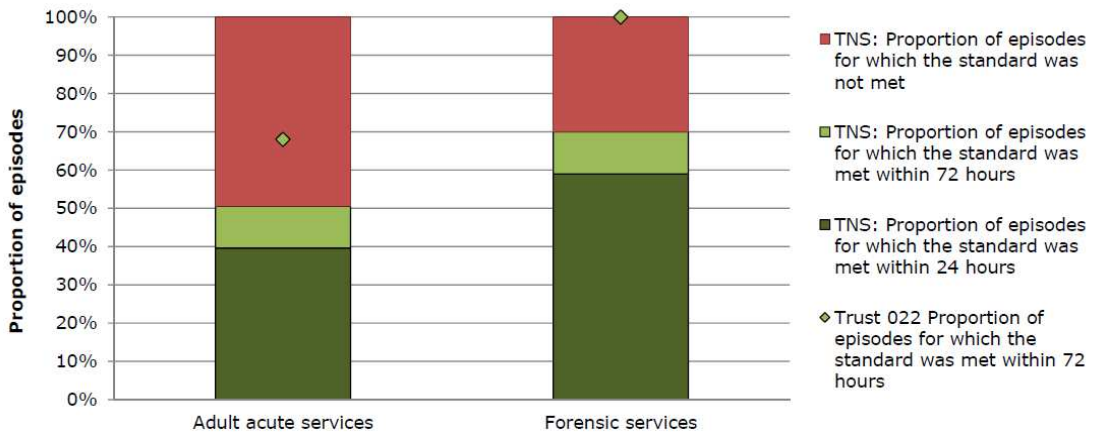


Perhaps the most interesting finding was that overall, nearly two thirds of patients felt that having an LAI would keep them out of hospital for longer and amongst current users of LAIs over three quarters believed this to be the case.

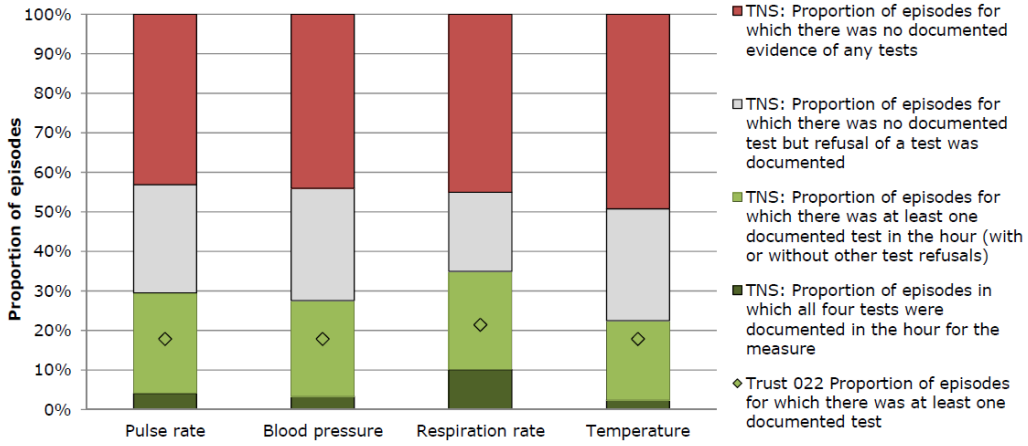
POMH-UK – audit of rapid tranquilisation

Last year the trust participated in a national audit of rapid tranquilisation. The results were published recently.

In summary, a higher proportion of patients in SLAM than in the average national sample received a prompt debrief following parenteral administration of medication, as shown below. However, the future management of acutely disturbed behaviour was not evident in the written care plan for any patient in SLAM included in the audit. SLAM is trust T022 and TNS is the average national sample.



The majority of patients in SLAM did not have evidence in ePJS of physical health monitoring in the hour immediately after parenteral medication administration, as shown below.



The physical health monitoring guidance is available in the medicines policy on the link below.

http://sites.intranet.slam.nhs.uk/Policies/ClinicalPatient%20Safety/Medicines%20Policy,%20v6.1%20-%20June%202017/7.%20Medicines%20Policy%20v6.1%20June%202017%20-%20(Appendices%2024-25)%20Guidelines%20for%20Rapid%20Tranquilisation.pdf

Clinicians are reminded that MEWS charts must be scanned into ePJS.

South East London Area Prescribing Committee (SEL APC) – approval of guanfacine for ADHD in children and adolescents

The SEL APC has approved guanfacine for the treatment of ADHD in children and adolescents in secondary care. Guanfacine should be considered a third-line option, after methylphenidate and atomoxetine. Prescribing must be initiated by a consultant. The prescriber must complete an initiation form for each child starting guanfacine. Baseline and subsequent assessments are outlined in the initiation form. GPs are not yet permitted to continue the prescription of guanfacine.

Patient safety alert bulletin – valproate for women of childbearing age

Valproate use in pregnancy is associated with birth defects and developmental delays: the risks are estimated to be around 10% and 30-40% respectively. NHS England (NHSE) reports that despite communications to prescribers about the risks of valproate in pregnancy many women taking valproate remain unaware of these risks.

In April, NHSE issued a patient safety alert (see link below), once again reminding prescribers to only prescribe valproate for women of childbearing age if other treatments are either ineffective or not tolerated. A number of resources have been specifically designed to ensure the safe use of valproate in cases where its use is deemed to be necessary. The alert below contains a link to these resources.

https://improvement.nhs.uk/uploads/documents/Patient_Safety_Alert_-_Resources_to_support_safe_use_of_valproate.pdf

The recommendations are summarised below:

Before starting valproate	During maintenance treatment
Consider an alternative agent to valproate, e.g., olanzapine. Lithium may also be considered as an alternative, although it too is best avoided during the first trimester of pregnancy and in patients who are poorly compliant with treatment. If valproate prescription is considered essential complete the MHRA checklist, available on the link below https://www.gov.uk/government/publications/toolkit-on-the-risks-of-valproate-medicines-in-female-patients	If valproate prescription is considered essential ensure that the MHRA checklist (below) has been completed https://www.gov.uk/government/publications/toolkit-on-the-risks-of-valproate-medicines-in-female-patients
Inform the patient of the risks of valproate in pregnancy and the need for adequate contraception. Prescribe folic acid 5mg. Give a valproate patient leaflet and card, available on the link below https://www.gov.uk/government/publications/toolkit-on-the-risks-of-valproate-medicines-in-female-patients	Ensure that the patient has been informed of the risks of valproate in pregnancy and the need for adequate contraception. Prescribe folic acid 5mg. Give a valproate patient leaflet and card, available on the link below https://www.gov.uk/government/publications/toolkit-on-the-risks-of-valproate-medicines-in-female-patients

Discharge medication counselling by pharmacy

Patients discharged from an in-patient unit are now seen by a member of the pharmacy team before they leave the ward. Patients are informed about the purpose of their medication and the directions for their use. As part of the session patients are asked if they have any questions or concerns about their medication.

A summary of the discussion is recorded in ePJS in the 'discharge notification tab'. The pharmacist also updates the current prescription in this section of ePJS. Ward doctors should approve the medication section when sending the discharge notification to GPs.

One particular benefit of this pharmacy scheme is that the medication section of the discharge notification will automatically update the 'medication tab' in ePJS. We hope over time to create accurate records of the ePJS 'medication tab' for many patients through this process.

For further information contact Kwame.peprah@slam.nhs.uk or seema.varma@slam.nhs.uk

Medicines Safety Committee

The trust Medicines Safety Committee meets every three months. One of the main responsibilities of the group is to review trust reported medication incidents and to make recommendations on how medicines safety can be improved in the trust. Presented below is a summary of the incidents reported on DATIX between February and May 2017.

Type of error	Number of incidents reported			
	February	**March**	**April**	**Total**
Prescribing	6	5	7	**18**
Administration on wards and HTTs	24	24	25	**73**
Pharmacy	9	13	15	**37**
Missing Drugs/Controlled Stationary/Keys	3	4	5	**12**
Issuing Of Medication from CMHTs and HTTs	0	2	0	**2**
Total	**42**	**48**	**52**	**142**

The trust error reporting policy states that all medication errors should be reported on DATIX. Those that reach or nearly reach the patient, regardless of outcome, are reported as at least 'Category C'. Errors which result in serious harm are reported as a 'B' and death as an 'A'. All trust staff must know the procedure for reporting an error on DATIX. If you don't know how to report or have any questions about reporting medication errors please contact Datixweb@slam.nhs.uk

Examples of medication errors reported recently on DATIX are shown below:

Type of error	Examples of reported errors
Prescribing	Half the daily dose of valproate prescribed on re-writing the drug chart
	Insulin prescribed once instead of twice a day on rewriting the drug chart
	Flupentixol depot prescribed instead of zuclopentixol
Pharmacy	Flupentixol depot dispensed instead of fluphenazine
	Gabapentin supplied instead of pregabalin
Administration	Lurasidone prescribed and administered twice instead of once a day
	Trevicta® (paliperidone 3-monthly injection) administered 5 weeks earlier than due date
	Colecalciferol 40000 units administered daily for six days instead of weekly.
	Risperidone Consta 75mg administered instead of paliperidone 75mg
	Depot not given before transfer to another ward. Date of last depot was not recorded on chart. Not given on new ward as assumed to have been given already.
	HIV medication not administered and recorded as out of stock despite being on the ward
Other	Patient retitrated on clozapine. Supported home did not realise patient missed >3 days of treatment
	Patient received nearly a month of two antipsychotics because oral not stopped by GP when depot started by CMHT

Shubhra Mace and David Taylor September 2017

References

1. McEvoy JP, Byerly M, Hamer RM, Dominik R, Swartz MS, Rosenheck RA, et al. Effectiveness of paliperidone palmitate vs haloperidol decanoate for maintenance treatment of schizophrenia: a randomized clinical trial. JAMA. 2014; 311(19): 1978-87.
2. Attard A, Olofinjana O, Cornelius V, Curtis V, Taylor D. Paliperidone palmitate long-acting injection--prospective year-long follow-up of use in clinical practice. Acta PsychiatrScand. 2014; 130(1): 46-51.